Advance Directives in California

Advance directives are written instructions which communicate your wishes about the care and treatment you want if you reach a point where you can no longer make your own health care decisions.

Under California law adult persons with decision making capabilities have the right to accept or refuse medical treatment or life-sustaining procedures. Artificial nutrition and hydration are among the medical procedures you have the right to refuse or accept.

Reasons Why You May Want to Prepare an Advance Directive:

- To ensure you receive the care and services you desire.
- To ensure the refusal of treatment at a determined stage if you have previously stated your desires to do so.
- To designate the person you would like to make decisions on your behalf.
- To ensure that family and friends understand your wishes regarding health care. If you do not make your wishes clear, your family members and friends may not agree about what type of care and treatment you would want. It is possible that your desires will not be carried out, since a conflict may lead to a lengthy court delay.

You have the right to prepare an advance directive, such as a "living will," or "durable power of attorney for health care." An advance directive is a document that allows you to say in advance what you would want to happen if you reach a point where you can't make decisions for yourself or speak about them.

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is a legally binding document that allows the person you choose (the "agent") to make health decisions for you if and when you are no longer able to make such decisions. You should select a person who knows you well, and whom you trust. Your agent may be a relative or a friend, but must not be your attending doctor. The durable power of attorney for health care allows your agent to make any and all health care decisions for you once you are no longer able to decide. This includes routine medical decisions, such as whether you should have a flu shot, and more complicated decisions, such as whether you should have cataract surgery. You agent can even decide to withdraw or withhold life-sustaining procedures if you give your agent that authority.

To be valid, the document must be signed by you. The document must also be witnessed by two qualified adult witnesses, one who must be with the Ombudsman Program if you are living in a nursing home. Those persons not eligible to be witnesses are your doctor, the agent you are choosing or an employee of the nursing home. One of the two people may not be a relative or someone named in your will.

- You DO NOT need a lawyer to fill out a durable power of attorney for health care.
- A nursing home CANNOT require you to sign a durable power of attorney for health care.
- The durable power of attorney for health care allows you, in writing, to declare your desire to receive or not receive life-sustaining treatment under certain conditions. You may list any instructions you want pertaining to health care.

For more information about advance directives, contact:

California Department of Aging
1600 "K" Street
Sacramento, CA 96814-4020
916-322-3887
Toll free: 1-800-510-2020
Or
State Ombudsman Program
916-323-6681

17021-4/01

Durable Power of Attorney for Health Care

(California Probate Code Section 4771)

Warning to person executing this document:

This is an important legal document that is authorized by the Keene Health Care Agent Act. Before executing this document, you should know these important facts:

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known. Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the articular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time. This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition.

This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

The powers given by this document will exist for an indefinite period of time unless you limit their duration in this document. You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital or other health care provider orally or in writing of the revocation. Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document. Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

This document revokes any prior durable power of attorney for health care. You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

Do not use this form if you are a conservatee under the Lanterman-Petris-Short Act and you want to appoint your conservator as your agent. You can do that only if the appointment document includes a certificate of your attorney.

Durable Power of Attorney for Health Care

(California Probate Code Section 4771)

1. Designation of Health Care Agent.

I, ____

____

(Insert your name and address.)

do hereby designate and appoint

____

____

(Insert name, address and telephone number of one individual only as your agent to make health care decisions for you.)

as my agent to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental condition.

(None of the following may be designated as your agent: [1] your treating health care provider, [2] a nonrelative employee of your treating health care provider, [3] an operator of a community care facility, [4] a nonrelative employee of an operator of a community care facility, [5] an operator of a residential care facility for the elderly or [6] a nonrelative employee of an operator of a residential care facility for the elderly.)

2. Creation of Durable Power of Attorney for Health Care.

By this document I intend to create a durable power of attorney for health care under Sections 4600 to 4752, inclusive, of the California Probate Code. This power of attorney is authorized by the Keene Health Care Agent Act and shall be construed in accordance with the provisions of Sections 4770 to 4779, inclusive, of the Probate Code. This power of attorney shall not be affected by my subsequent incapacity.

3. General Statement of Authority Granted.

Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make those decisions for myself if I had the capacity to do so.

In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special Provisions and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. Statement of Desires, Special Provisions and Limitations.

Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided on the following page. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space provided on the following page. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space provided on the following page. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services and procedures:

____
____
____
____
____
____
____
____

(b) Additional statement of desires, special provisions and limitations:

____
____
____
____
____
____
____
____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

5. Inspection and Disclosure of Information Relating to My Physical or Mental Health.

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ["Statement of Desires, Special Provisions and Limitations"] above.)

6. Signing Documents, Waivers and Releases.

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. Autopsy; Anatomical Gifts; Disposition of Remains.

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Authorize an autopsy under Section 7113 of the Health and Safety Code.

(b) Make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5 [commencing with Section 7150] of Part 1 of Division 7 of the Health and Safety Code).

(c) Direct the disposition of my remains under Section 7100 of the Health and Safety Code. (If you want to limit the authority of your agent to consent to an autopsy, make an anatomical gift or direct the disposition of your remains, you must state the limitations in paragraph 4 ["Statement of Desires, Special Provisions and Limitations"] on the previous page.)

8. Duration.

(Unless you specify otherwise in the space below, this power of attorney will exist for an indefinite period of time.)

This durable power of attorney for health care expires on __________________. (Fill in this space ONLY if you want to limit the duration of this power of attorney.)

9. Designation of Alternate Agents.

(You are not required to designate any alternate agents, but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, these persons to serve in the order listed below:

A. First Alternate Agent ____

____

(Insert name, address and telephone number of first alternate agent.)

B. Second Alternate Agent ____

____

(Insert name, address and telephone number of second alternate agent.)

10. Nomination of Conservator of Person.

(A conservator of the person may be appointed for you if a court decides that one should be appointed. The conservator is responsible for your physical care, which under some circumstances includes making health care decisions for you. You are not required to nominate a conservator, but you may do so. The court will appoint the person you nominate unless that would be contrary to your best interests. You may, but are not required to, nominate as your conservator the same person you named in paragraph 1 as your health care agent. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person: ____

____

(Insert name and address of person nominated as conservator of the person.)

11. Prior Designations Revoked.

I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

Date: ____________________

City ____ State ______

Signature: ____
(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility, (6) the operator of a residential care facility for the elderly, or (7) an employee of an operator of a residential care facility for the elderly. At least one of the witnesses shall make the additional declaration set out following the place where the witnesses sign.)

(READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence.)

(To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within five years.

(3) Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:

(a) A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.

(b) A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue drivers' licenses.

(c) An identification card issued by a state other than California.

(d) An identification card issued by any branch of the armed forces of the United States.

(4) If the principal is a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrator or staff of the skilled nursing facility, or of family members, as convincing evidence of the identity of the principal if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

(Other kinds of proof of identity are not allowed.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

Signature: ____________________________ Residence Address: ____

Print Name: ____

Date: ______________________

Signature: ____________________________ Residence Address: ____

Print Name: ____

Date: ______________________

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the principal's estate upon the principal's death under a will now existing or by operation of law.

Signature: ____

Signature: ____

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

(If you are a patient in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman. The following statement is required only if you are a patient in a skilled nursing facility — a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign both parts of the "Statement of Witnesses" above AND must also sign the following statement.)

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by subdivision (e) of Section 4701 of the Probate Code.

Signature: ____